

AMENDED IN ASSEMBLY APRIL 15, 2009

CALIFORNIA LEGISLATURE—2009—10 REGULAR SESSION

ASSEMBLY BILL

No. 562

Introduced by Assembly Member Cook

February 25, 2009

An act to add Article 12 (commencing with Section 1399.850) to Chapter 2.2 of Division 2 of the Health and Safety Code, and to add Chapter 7.5 (commencing with Section 10650) to Part 2 of Division 2 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 562, as amended, Cook. Health care coverage: report of claim information.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance.

Existing law, the federal Health Insurance Portability and Accountability Act of 1996, establishes certain requirements relating to the provision of health insurance and the protection of privacy of individually identifiable health information. The act authorizes group health plans to permit health insurance issuers, as defined, to disclose protected health information to plan sponsors if specified requirements are met.

This bill would, on and after July 1, 2010, require a health insurance issuer that receives a written request for a written report of claim information from a plan, plan sponsor, or plan administrator with respect to a group health plan issued by the issuer, to provide that report to the requesting party no later than 30 days after receipt of the request. The

bill would require the report to be provided in a specified manner and to include specified information. The bill would prohibit the health insurance issuer from disclosing any information protected under federal or state law, ~~and would also prohibit the issuer from disclosing protected health information to the plan sponsor unless an authorized representative of the plan sponsor makes a specified certification.~~ The bill would make a health insurance issuer that fails to comply with these requirements subject to administrative penalties. The bill would define various terms and enact related provisions.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Article 12 (commencing with Section 1399.850)
2 is added to Chapter 2.2 of Division 2 of the Health and Safety
3 Code, to read:

4
5 Article 12. Reporting of ~~Claims~~ *Claim* Information

6
7 1399.850. (a) For purposes of this article, except as provided
8 in subdivision (b), the following terms have the following
9 meanings:

10 (1) “Employer” ~~has the same meaning as that term is~~ *means an*
11 *employer, as defined in Section 1002(5) of Title 29 of the United*
12 *States Code, with more than 50 employees. “Employer” does not*
13 *include a small employer, as defined in subdivision (l) of Section*
14 *1357.*

15 (2) “Governmental entity” means a state agency or political
16 subdivision of the state *with more than 50 employees.*
17 *“Governmental entity” does not include a governmental entity*
18 *that is a small employer, as defined in subdivision (l) of Section*
19 *1357.*

20 (3) “Group health plan” has the same meaning as that term is
21 defined in Section 160.103 of Title 45 of the Code of Federal
22 Regulations, except that the term does not include disability income
23 insurance or long-term care insurance.

24 (4) “Health insurance issuer” has the same meaning as that term
25 is defined in Section 160.103 of Title 45 of the Code of Federal
26 Regulations.

1 (5) “Plan” means an employee welfare benefit plan, as defined
2 in Section 1002(1) of Title 29 of the United States Code.

3 (6) “Plan administrator” means an administrator, as defined in
4 Section 1002(16)(A) of Title 29 of the United States Code, *relative*
5 *to an employer with more than 50 employees. “Plan administrator”*
6 *does not include a plan administrator for a small employer, as*
7 *defined in subdivision (l) of Section 1357.*

8 (7) “Plan sponsor” has the same meaning as that term is defined
9 in Section 1002(16)(B) of Title 29 of the United States Code,
10 *relative to an employer with more than 50 employees. “Plan*
11 *sponsor” does not include a plan sponsor for a small employer,*
12 *as defined in subdivision (l) of Section 1357.*

13 (8) “Political subdivision” means a county, municipality, school
14 district, special-purpose district, or other subdivision of state
15 government that has jurisdiction limited to a geographic portion
16 of the state.

17 (9) “Protected health information” has the same meaning as that
18 term is defined in Section 160.103 of Title 45 of the Code of
19 Federal Regulations.

20 (b) A reference to a federal statute or regulation under
21 subdivision (a) refers to that statute or regulation as it existed on
22 January 1, 2009, except that the director may, by rule, in
23 consultation with the Insurance Commissioner, adopt a definition
24 based on a later amended, enacted, or adopted federal statute or
25 regulation if the director determines that use of the later amended,
26 enacted, or adopted statute or regulation is consistent with the
27 purposes of this article and promotes regulatory consistency.

28 1399.851. (a) This article shall apply to a governmental entity
29 that enters into a contract with a health insurance issuer that results
30 in the health insurance issuer delivering, issuing for delivery, or
31 renewing a group health plan.

32 (b) For purposes of this chapter, a health insurance issuer shall
33 treat a governmental entity described in subdivision (a) as a plan
34 sponsor or plan administrator.

35 (c) A report of claim information provided under this section
36 to a governmental entity is confidential and exempt from public
37 disclosure under Chapter 3.5 (commencing with Section 6250) of
38 Division 7 of Title 1 of the Government Code.

39 1399.852. (a) A health insurance issuer that receives a written
40 request for a written report of claim information from a plan, plan

1 sponsor, or plan administrator with respect to a group health plan
2 issued by the issuer shall provide that report, consistent with the
3 requirements of this section, to the requesting party no later than
4 30 days after receipt of the request. The health insurance issuer
5 shall not be required to provide a report under this subdivision
6 regarding a particular employer or group health plan more than
7 twice in a 12-month period.

8 (b) A health insurance issuer shall provide the report of claim
9 information required pursuant to subdivision (a) by one of the
10 following means:

11 (1) In a written report.

12 (2) Through an electronic file transmitted by secure electronic
13 mail or a file transfer protocol site.

14 (3) By making the required information available through a
15 secure Internet Web site or Web portal accessible by the requesting
16 plan, plan sponsor, or plan administrator.

17 (c) A report of claim information provided under this section
18 shall contain all information available to the health insurance issuer
19 that is responsive to the request for the 36-month period preceding
20 the date of the report or the entire period of coverage, whichever
21 period is shorter, except as provided in paragraphs (5) and (6).
22 Except as provided in subdivisions (d) and (e), the report required
23 by this section shall include all of the following information:

24 (1) Aggregate paid claims experience by month, including, but
25 not limited to, claims experience for medical, dental, and pharmacy
26 benefits, *including capitation costs or payments in the case of*
27 *health maintenance organizations*, as applicable. *Twenty thousand*
28 *dollars (\$20,000) shall be used as the pooling point for aggregate*
29 *reporting.*

30 (2) Total premiums paid by month.

31 (3) The total number of covered employees on a monthly basis
32 by coverage tier, including whether the coverage was for one of
33 the following:

34 (A) An employee only.

35 (B) An employee with dependents only.

36 (C) An employee with a spouse only.

37 (D) An employee with a spouse and dependents.

38 (4) The total dollar amount of claims pending as of the date of
39 the report.

(5) A separate description and individual claims report for any individual whose total paid claims exceed ~~fifteen thousand dollars (\$15,000)~~ *twenty thousand dollars (\$20,000)* during the 12-month period preceding the date of the report. This report shall include ~~all both~~ of the following information related to the claims for that individual:

~~(A) A unique identifying number, characteristic, or code for the individual.~~

~~(B)~~

(A) The amounts paid during the 12-month period.

~~(C) The dates on which health care services were provided during the 12-month period.~~

~~(D)~~

(B) The applicable procedure codes and diagnosis codes.

~~(6) For claims that are not part of the report described by paragraphs (1) to (5), inclusive, a statement describing precertification requests for hospital stays of five days or longer that were made during the 30-day period preceding the date of the report.~~

(d) A health insurance issuer shall not disclose any information in the report required under this section that the health insurance issuer is prohibited from disclosing under another state or federal law that imposes more stringent privacy restrictions than those imposed under federal law under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191). ~~In order to withhold information in accordance with this subdivision, the health insurance issuer shall do both of the following:~~

~~(1) Notify the plan, plan sponsor, or plan administrator requesting the report that information is being withheld.~~

~~(2) Provide to the plan, plan sponsor, or plan administrator requesting the report a list of categories of claim information that the health insurance issuer has determined are subject to the more stringent privacy restrictions under another state or federal law.~~

(e) A plan sponsor shall not receive protected health information under paragraph (5) or (6) of subdivision (c) unless an appropriately authorized representative of the plan sponsor makes a certification to the health insurance issuer that is substantially similar to the following:

1 ~~“I hereby certify that the plan documents comply with the~~
2 ~~requirements of 45 C.F.R. Section 164.504(f)(2) and that the plan~~
3 ~~sponsor will safeguard and limit the use and disclosure of protected~~
4 ~~health information that the plan sponsor may receive from the~~
5 ~~group health plan to perform plan administration functions.”~~

6
7 (f)

8 (e) If a health insurance issuer receives a request under
9 subdivision (a) after the date that coverage under the applicable
10 group health plan has terminated, the report required under
11 subdivision (a) shall contain all information available to the health
12 insurance issuer that is responsive to the request for the period
13 described in subdivision (c) preceding the date of termination of
14 coverage or for the entire policy period, whichever period is
15 shorter. The report shall include the information described in
16 paragraphs (1) to (6) (5), inclusive, of subdivision (c), ~~but it shall~~
17 ~~not include any protected health information required under~~
18 ~~paragraph (5) or (6) of subdivision (c) unless a certification has~~
19 ~~been provided in accordance with subdivision (c).~~

20 (g)

21 (f) In order to be entitled to receive the report described in this
22 section, a plan, plan sponsor, or plan administrator shall request
23 that report on or before the second anniversary of the date of
24 termination of coverage under a group health plan issued by the
25 health insurance issuer.

26 1399.853. (a) No later than 10 days after receiving the report
27 described in Section 1399.852, a plan, plan sponsor, or plan
28 administrator may make a written request to the health insurance
29 issuer for additional information regarding specified individuals
30 in accordance with this section.

31 (b) ~~With respect to a request for additional information~~
32 ~~concerning specified individuals for whom claims information~~
33 ~~was provided under paragraph (5) of subdivision (c) of Section~~
34 ~~1399.852, the health insurance issuer shall provide additional~~
35 ~~information on the prognosis or recovery of the individual, if~~
36 ~~available, and for individuals in active case management, the most~~
37 ~~recent case management information relating to the claims for that~~
38 ~~individual, including any future expected costs and treatment plans.~~

39 (c) ~~The health insurance issuer shall respond to a request for~~
40 ~~additional information under this section no later than 15 days~~

1 after the date of the request unless the requesting plan, plan
2 sponsor, or plan administrator agrees to a request for additional
3 time.

4 (d) The health insurance issuer shall not provide the information
5 described in this section unless a certification has been provided
6 in accordance with subdivision (e) of Section 1399.852.

7 1399.854. A health insurance issuer that releases information,
8 including, but not limited to, protected health information, in
9 accordance with this article shall not be in violation of a standard
10 of care. In addition, the health insurance issuer shall not be held
11 liable for civil damages resulting from, or subject to criminal
12 prosecution for, releasing that information in accordance with this
13 article.

14 1399.855.

15 1399.853. For purposes of this article, Sections 1374.8 and
16 1390 shall not apply.

17 1399.856.

18 1399.854. A health insurance issuer that fails to comply with
19 this article is subject to administrative penalties.

20 1399.857.

21 1399.855. This article applies only to a request for a written
22 report of claim information made on or after July 1, 2010.

23 SEC. 2. Chapter 7.5 (commencing with Section 10650) is added
24 to Part 2 of Division 2 of the Insurance Code, to read:

25
26 CHAPTER 7.5. REPORTING OF ~~CLAIMS~~ CLAIM INFORMATION
27

28 10650. (a) For purposes of this chapter, except as provided in
29 subdivision (b), the following terms have the following meanings:

30 (1) "Employer" ~~has the same meaning as that term is~~ *means an*
31 *employer, as defined in Section 1002(5) of Title 29 of the United*
32 *States Code, with more than 50 employees. "Employer" does not*
33 *include a small employer, as defined in subdivision (w) of Section*
34 *10700.*

35 (2) "Governmental entity" means a state agency or political
36 subdivision of the state *with more than 50 employees.*
37 *"Governmental entity" does not include a governmental entity*
38 *that is a small employer, as defined in subdivision (w) of Section*
39 *10700.*

1 (3) “Group health plan” has the same meaning as that term is
2 defined in Section 160.103 of Title 45 of the Code of Federal
3 Regulations, except that the term does not include disability income
4 insurance or long-term care insurance.

5 (4) “Health insurance issuer” has the same meaning as that term
6 is defined in Section 160.103 of Title 45 of the Code of Federal
7 Regulations.

8 (5) “Plan” means an employee welfare benefit plan, as defined
9 in Section 1002(1) of Title 29 of the United States Code.

10 (6) “Plan administrator” means an administrator, as defined in
11 Section 1002(16)(A) of Title 29 of the United States Code, *relative*
12 *to an employer with more than 50 employees. “Plan administrator”*
13 *does not include a plan administrator for a small employer, as*
14 *defined in subdivision (w) of Section 10700.*

15 (7) “Plan sponsor” has the same meaning as that term is defined
16 in Section 1002(16)(B) of Title 29 of the United States Code,
17 *relative to an employer with more than 50 employees. “Plan*
18 *sponsor” does not include a plan sponsor for a small employer,*
19 *as defined in subdivision (w) of Section 10700.*

20 (8) “Political subdivision” means a county, municipality, school
21 district, special-purpose district, or other subdivision of state
22 government that has jurisdiction limited to a geographic portion
23 of the state.

24 (9) “Protected health information” has the same meaning as that
25 term is defined in Section 160.103 of Title 45 of the Code of
26 Federal Regulations.

27 (b) A reference to a federal statute or regulation under
28 subdivision (a) refers to that statute or regulation as it existed on
29 January 1, 2009, except that the commissioner may, by rule, in
30 consultation with the Director of Managed Health Care, adopt a
31 definition based on a later amended, enacted, or adopted federal
32 statute or regulation if the commissioner determines that use of
33 the later amended, enacted, or adopted statute or regulation is
34 consistent with the purposes of this chapter and promotes
35 regulatory consistency.

36 10651. (a) This chapter shall apply to a governmental entity
37 that enters into a contract with a health insurance issuer that results
38 in the health insurance issuer delivering, issuing for delivery, or
39 renewing a group health plan.

1 (b) For purposes of this chapter, a health insurance issuer shall
2 treat a governmental entity described in subdivision (a) as a plan
3 sponsor or plan administrator.

4 (c) A report of claim information provided under this section
5 to a governmental entity is confidential and exempt from public
6 disclosure under Chapter 3.5 (commencing with Section 6250) of
7 Division 7 of Title 1 of the Government Code.

8 10652. (a) A health insurance issuer that receives a written
9 request for a written report of claim information from a plan, plan
10 sponsor, or plan administrator with respect to a group health plan
11 issued by the issuer shall provide that report, consistent with the
12 requirements of this section, to the requesting party no later than
13 30 days after receipt of the request. The health insurance issuer
14 shall not be required to provide a report under this subdivision
15 regarding a particular employer or group health plan more than
16 twice in a 12-month period.

17 (b) A health insurance issuer shall provide the report of claim
18 information required pursuant to subdivision (a) by one of the
19 following means:

20 (1) In a written report.

21 (2) Through an electronic file transmitted by secure electronic
22 mail or a file transfer protocol site.

23 (3) By making the required information available through a
24 secure Internet Web site or Web portal accessible by the requesting
25 plan, plan sponsor, or plan administrator.

26 (c) A report of claim information provided under this section
27 shall contain all information available to the health insurance issuer
28 that is responsive to the request for the 36-month period preceding
29 the date of the report or the entire period of coverage, whichever
30 period is shorter, except as provided in paragraphs (5) and (6).
31 Except as provided in subdivisions (d) and (e), the report required
32 by this section shall include all of the following information:

33 (1) Aggregate paid claims experience by month, including, but
34 not limited to, claims experience for medical, dental, and pharmacy
35 benefits, *including capitation costs or payments in the case of*
36 *contracts with providers at alternative rates pursuant to Section*
37 *10133, as applicable. Twenty thousand dollars (\$20,000) shall be*
38 *used as the pooling point for aggregate reporting.*

39 (2) Total premiums paid by month.

(3) The total number of covered employees on a monthly basis by coverage tier, including whether the coverage was for one of the following:

- (A) An employee only.
- (B) An employee with dependents only.
- (C) An employee with a spouse only.
- (D) An employee with a spouse and dependents.

(4) The total dollar amount of claims pending as of the date of the report.

(5) A separate description and individual claims report for any individual whose total paid claims exceed ~~fifteen thousand dollars (\$15,000)~~ *twenty thousand dollars (\$20,000)* during the 12-month period preceding the date of the report. This report shall include ~~all both~~ of the following ~~information~~ related to the claims for that individual:

~~(A) A unique identifying number, characteristic, or code for the individual.~~

~~(B)~~

(A) The amounts paid during the 12-month period.

~~(C) The dates on which health care services were provided during the 12-month period.~~

~~(D)~~

(B) The applicable procedure codes and diagnosis codes.

~~(6) For claims that are not part of the report described by paragraphs (1) to (5), inclusive, a statement describing precertification requests for hospital stays of five days or longer that were made during the 30-day period preceding the date of the report.~~

(d) A health insurance issuer shall not disclose any information in the report required under this section that the health insurance issuer is prohibited from disclosing under another state or federal law that imposes more stringent privacy restrictions than those imposed under federal law under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191). ~~In order to withhold information in accordance with this subdivision, the health insurance issuer shall do both of the following:~~

~~(1) Notify the plan, plan sponsor, or plan administrator requesting the report that information is being withheld.~~

~~(2) Provide to the plan, plan sponsor, or plan administrator requesting the report a list of categories of claim information that~~

1 the health insurance issuer has determined are subject to the more
2 stringent privacy restrictions under another state or federal law.

3 (e) ~~A plan sponsor shall not receive protected health information~~
4 ~~under paragraph (5) or (6) of subdivision (c) unless an appropriately~~
5 ~~authorized representative of the plan sponsor makes a certification~~
6 ~~to the health insurance issuer that is substantially similar to the~~
7 ~~following:~~

8
9 “~~I hereby certify that the plan documents comply with the~~
10 ~~requirements of 45 C.F.R. Section 164.504(f)(2) and that the plan~~
11 ~~sponsor will safeguard and limit the use and disclosure of protected~~
12 ~~health information that the plan sponsor may receive from the~~
13 ~~group health plan to perform plan administration functions.”~~

14
15 (f)

16 (e) If a health insurance issuer receives a request under
17 subdivision (a) after the date that coverage under the applicable
18 group health plan has terminated, the report required under
19 subdivision (a) shall contain all information available to the health
20 insurance issuer that is responsive to the request for the period
21 described in subdivision (c) preceding the date of termination of
22 coverage or for the entire policy period, whichever period is
23 shorter. The report shall include the information described in
24 paragraphs (1) to ~~(6)~~ (5), inclusive, of subdivision (c); ~~but it shall~~
25 ~~not include any protected health information required under~~
26 ~~paragraph (5) or (6) of subdivision (c) unless a certification has~~
27 ~~been provided in accordance with subdivision (e).~~

28 (g)

29 (f) In order to be entitled to receive the report described in this
30 section, a plan, plan sponsor, or plan administrator shall request
31 that report on or before the second anniversary of the date of
32 termination of coverage under a group health plan issued by the
33 health insurance issuer.

34 10653. ~~(a) No later than 10 days after receiving the report~~
35 ~~described in Section 10652, a plan, plan sponsor, or plan~~
36 ~~administrator may make a written request to the health insurance~~
37 ~~issuer for additional information regarding specified individuals~~
38 ~~in accordance with this section.~~

39 ~~(b) With respect to a request for additional information~~
40 ~~concerning specified individuals for whom claims information~~

1 was provided under paragraph (5) of subdivision (c) of Section
2 10652, the health insurance issuer shall provide additional
3 information on the prognosis or recovery of the individual, if
4 available, and for individuals in active case management, the most
5 recent case management information relating to the claims for that
6 individual, including any future expected costs and treatment plans.

7 (e) The health insurance issuer shall respond to a request for
8 additional information under this section no later than 15 days
9 after the date of the request unless the requesting plan, plan
10 sponsor, or plan administrator agrees to a request for additional
11 time.

12 (d) The health insurance issuer shall not provide the information
13 described in this section unless a certification has been provided
14 in accordance with subdivision (c) of Section 10652.

15 10654. A health insurance issuer that releases information,
16 including, but not limited to, protected health information, in
17 accordance with this chapter shall not be in violation of a standard
18 of care. In addition, the health insurance issuer shall not be held
19 liable for civil damages resulting from, or subject to criminal
20 prosecution for, releasing that information.

21 10655.

22 10653. For purposes of this chapter, Section 791.27 shall not
23 apply.

24 10656.

25 10654. A health insurance issuer that fails to comply with this
26 chapter is subject to administrative penalties.

27 10657.

28 10655. This chapter applies only to a request for a written
29 report of claim information made on or after July 1, 2010.